

KENTUCKY CERTIFICATE OF DEATH

116 201611296

Case #: E201604040167

1a. DECEDENT'S LEGAL NAME (First, Middle, Last) (Include AKA's if any) LORETTA ANN HYLANDER						1b. IF FEMALE, DECEDENT'S LAST NAME PRIOR TO FIRST MARRIAGE ERSKINE		2. SEX FEMALE	
3. ACTUAL OR PRESUMED DATE OF DEATH (Month/Day/Year) (Spell Month) April 03, 2016		4. SOCIAL SECURITY NUMBER 407-58-1304		5a. AGE-LAST BIRTHDAY (Years) 72		5b. UNDER 1 YEAR Months: Days: Hours: Minutes:		5c. UNDER 1 DAY Hours: Minutes:	
6. DATE OF BIRTH (MM/DD/YYYY) 01/25/1944		7. COUNTY OF DEATH FAYETTE							
8. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> Dead on Arrival OTHER: <input type="checkbox"/> Hospice Facility <input type="checkbox"/> Nursing Home/Long Term Care Facility <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
9. FACILITY NAME (If not institution, give street and number) UNIVERSITY OF KENTUCKY HOSPITAL						10. CITY OR TOWN, STATE AND ZIP CODE LEXINGTON, KY 40536			
11. BIRTHPLACE (City and State or Foreign Country) BURTONVILLE, KENTUCKY				12. MARITAL STATUS <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married but Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown		13. SURVIVING SPOUSE (If wife, give name prior to first marriage) ROYCE HYLANDER			
14. DECEDENT'S USUAL OCCUPATION (Kind of work done during most of working life.) (Do not use retired) HOMEMAKER				15. KIND OF BUSINESS/INDUSTRY DOMESTIC				16. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
17a. RESIDENCE - State KENTUCKY		17b. COUNTY FLEMING		17c. CITY OR TOWN WALLINGFORD		17d. STREET AND NUMBER 13365 KY 344		17e. ZIP CODE 41093	
17f. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
18. DECEDENT'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of death.) <input type="checkbox"/> 8th Grade or Less <input type="checkbox"/> 9th-12th Grade; No Diploma <input checked="" type="checkbox"/> High School Graduate or GED Completed <input type="checkbox"/> Some College Credit but No Degree <input type="checkbox"/> Associates Degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's Degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's Degree (e.g., MA, MS, MEd, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional Degree (e.g., MD, DDS, DVM, LLB, JD)				19. DECEDENT OF HISPANIC ORIGIN? (Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if the decedent is not Spanish/Hispanic/Latino.) <input checked="" type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify)				20. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be) <input checked="" type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian (Specify) <input type="checkbox"/> Other Pacific Islander (Specify) <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) <input type="checkbox"/> Other (Specify)	
21. FATHER'S NAME (First, Middle, Last) CLARENCE ERSKINE				22. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last) ELLEN ROLPH					
23a. INFORMANT'S NAME ROYCE HYLANDER				23b. RELATIONSHIP TO DECEDENT SPOUSE		23c. MAILING ADDRESS (Street and Number, City, State, Zip Code) 13365 KY 344, WALLINGFORD, KY 41093			
24. METHOD OF DISPOSITION (Check only one): <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Entombment <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify)				25. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place) ESHAM CEMETERY		26. LOCATION - City, Town, and State LEWIS COUNTY, KY			
27. SIGNATURE OF FUNERAL SERVICE LICENSEE (Or person acting as such) WILLIAM RUSSELL MCCREARY JR. (Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.118				DATE SIGNED (MM/DD/YYYY) 04/04/2016		28. KY LICENSE NUMBER (of license) 6502		29. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY BARBOUR & SON FUNERAL HOME PO BOX 247 TOLLESBORO, KY 41189	
30. DATE PRONOUNCED DEAD (MM/DD/YYYY) 04/03/2016				31. ACTUAL OR PRESUMED TIME OF DEATH 1237		32. WAS MEDICAL EXAMINER OR CORONER CONTACTED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
33. PART I. Enter the chain of events - diseases, injuries, or complications - that caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) -> a. ADULT RESPIRATORY DISTRESS SYNDROME DUE TO (OR AS A CONSEQUENCE OF): b. SEPTIC SHOCK DUE TO (OR AS A CONSEQUENCE OF): c. CIRRHOSIS DUE TO (OR AS A CONSEQUENCE OF): Enter the UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST d. PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in Part I									
34. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be Determined									
35. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		37. DID TOBACCO USE CONTRIBUTE TO DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> Probably <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown		38. IF FEMALE: <input checked="" type="checkbox"/> Not pregnant within past year <input type="checkbox"/> Not pregnant, but pregnant within 42 days of death <input type="checkbox"/> Not pregnant, but pregnant 43 days to 1 year before death <input type="checkbox"/> Pregnant at time of death <input type="checkbox"/> Unknown if pregnant within past year					
36. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No		39. DATE OF INJURY (Month/Day/Year) (Spell Month)		40. TIME OF INJURY		41. INJURY AT WORK? <input type="checkbox"/> Yes <input type="checkbox"/> No		42. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)	
43. IF TRANSPORTATION INJURY, SPECIFY: <input type="checkbox"/> Driver/Operator <input type="checkbox"/> Pedestrian <input type="checkbox"/> Passenger <input type="checkbox"/> Other (Specify)				44. DESCRIBE HOW INJURY OCCURRED:					
45. LOCATION OF INJURY (Street and Number, City or Town, State, Zip Code)									
46. TO BE COMPLETED BY CERTIFIER: To the best of my knowledge, death occurred at the time, date, and place, and due to cause(s) and manner stated. SIGNATURE KEVIN HARRIS SMITH, MD (Must Use Blue/Black Ink) Electronic signature is legally acceptable pursuant to KRS 369.107 & KRS 369.118						47. DATE CERTIFIED (MM/DD/YYYY) 04/11/2016			
50. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (ITEM 33) KEVIN SMITH UNIVERSITY OF KENTUCKY HOSPITAL, 800 ROSE STREET, N100, LEXINGTON, KY 40536						48. LICENSE NUMBER 43876		49. TITLE OF CERTIFIER PHYSICIAN	
51. REGISTRAR'S SIGNATURE <i>Paul J. Royce</i>						52. DATE FILED (MM/DD/YYYY) 04/11/2016			